STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM
BC-VOC-0101 (REV. 5/00)

# MENTAL HEALTH
# BILLING/VERIFICATION (B/V) FORM

FOR BOARD USE ONLY

(1) VOC CLAIM NUMBER

THIS FORM MUST BE COMPLETED FULLY

## SECTION 1: TO BE COMPLETED BY THE SERVICE PROVIDER AND INITIALED BY THE PATIENT

| | | |
|---|---|---|
| (2) NAME OF PROVIDER ORGANIZATION OR FACILITY (IF APPLICABLE) | ☐ FOR PROFIT | ☐ NONPROFIT |

| | | |
|---|---|---|
| (3) NAME OF TREATING THERAPIST | (4) LICENSE./REGISTRATION NO.(include prefix) | EFFECTIVE/EXPIRATION DATE |
| | | |

| | | | | |
|---|---|---|---|---|
| TREATING THERAPIST'S LICENSE TYPE: | ☐ MFT | ☐ MFT INTERN | ☐ LCSW | ☐ ASSOCIATE MSW |

| | | | |
|---|---|---|---|
| ☐ PSYCHIATRIST | ☐ PSYCH. ASSISTANT | ☐ LICENSED CLINICAL PSYCHOLOGIST | ☐ OTHER (PLEASE SPECIFY) ______________________ |

| | | |
|---|---|---|
| (5) NAME AND TITLE OF SUPERVISING THERAPIST (FOR INTERNS) | (6) SUPERVISOR'S LICENSE NUMBER (include prefix) | EFFECTIVE/EXPIRATION DATE OF SUPERVISING THERAPIST'S LICENSE |
| | | |

(7) IF AUTHORIZED, PAYMENT SHOULD BE ISSUED TO: ☐ ORGANIZATION ☐ TREATING THERAPIST ☐ SUPERVISING THERAPIST

(8) PAYEE'S TAX IDENTIFICATION NO.: SSN [ ] __________________ **OR** EIN [ ] __________________

| | | |
|---|---|---|
| (9) MAILING ADDRESS OF PAYEE (Including city, state, and zip code) | IS THIS A NEW ADDRESS? | TELEPHONE (Include area code) |
| | ☐ YES ☐ NO | |

| | | | | | |
|---|---|---|---|---|---|
| (10) DATES OF SERVICE | (11) DESCRIPTION OF SERVICE (INDIVIDUAL, GROUP, FAMILY, OTHER) | PROCEDURE CODE | SESSION LENGTH | BILLED AMOUNT | (12) PATIENT'S INITIALS |
| | ☐ IND ☐ GRP ☐ FAM ☐ OTHER | | | | |
| | ☐ IND ☐ GRP ☐ FAM ☐ OTHER | | | | |
| | ☐ IND ☐ GRP ☐ FAM ☐ OTHER | | | | |
| | ☐ IND ☐ GRP ☐ FAM ☐ OTHER | | | | |
| | ☐ IND ☐ GRP ☐ FAM ☐ OTHER | | | | |

| | |
|---|---|
| PART OF TREATMENT NECESSARY TO ADDRESS THE EFFECTS OF THE QUALIFYING CRIME: 50% OR LESS ☐ OVER 50% ☐ 100% ☐ | TOTAL CHARGES FOR THIS BILL |

| | | | |
|---|---|---|---|
| AMT PAID BY PATIENT | DOES PT. HAVE INSURANCE? ☐ YES ☐ NO | AMOUNT BILLED TO & PAID BY INSURANCE | DO YOU ACCEPT MEDI-CAL? ☐ YES ☐ NO |

| | | |
|---|---|---|
| AMOUNT WRITTEN OFF | AMOUNT PAID BY OTHER | IF PAID BY OTHER, WHOM WAS THE PAYMENT MADE TO? |
| | | |

Is the counselor funded partially or wholly by **Federal VOCA grants or matching funds**? ☐ YES ☐ NO
**NOTE**: IF THE ANSWER IS YES, THESE SERVICES ARE **NOT** ELIGIBLE FOR REIMBURSEMENT FROM THE VOC PROGRAM

PROVIDER DECLARATION: I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form, and to the best of my information and belief, all my answers are true, correct, and complete, and; (2) all treatment noted on this form was necessary as a direct result of the crime described on the patient's original Crime Victim Compensation Application. I further understand that if I have provided any information that is false, intentionally incomplete, or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and may also be guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

_______________________________ THERAPIST'S SIGNATURE

__________ DATE

_______________________________ SUPERVISING THERAPIST'S SIGNATURE

__________ DATE

## (14) SECTION II: TO BE COMPLETED BY PATIENT

| | | | |
|---|---|---|---|
| PATIENT NAME (First, middle initial, last) | SOCIAL SECURITY NO. | DATE OF BIRTH | PHONE NO. (Work/home) |
| | | | |

| | |
|---|---|
| MAILING ADDRESS (Including city, state, and zip code | IS THIS A NEW ADDRESS? YES [ ] NO [ ] |

PATIENT DECLARATION: I declare under penalty of perjury that I received the services listed on he date(s) indicated, that all treatment sessions on this form are directly related to the crime described on my original Crime Victim Compensation Application and that I have signed/initialed this form only after the services were provided.

_______________________________________________ (15) PATIENT'S SIGNATURE (Parent or Guardian's Signature if Patient is under age 18)

__________________ DATE

# MENTAL HEALTH
# BILLING/VERIFICATION (B/V) FORM

STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM
BC-VOC-O101 (REV. 6/00)

PAGE _____ OF _____

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VOC CLAIM NUMBER

| DATES OF SERVICE | (11) DESCRIPTION OF SERVICE (INDIVIDUAL, GROUP, FAMILY, OTHER) | | | | PROCEDURE CODE | SESSION LENGTH | BILLED AMOUNT | PATIENT'S INITIALS |
|---|---|---|---|---|---|---|---|---|
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |
| | ☐ IND | ☐ GRP | ☐ FAM | ☐ OTHER | | | | |

## INSTRUCTIONS FOR COMPLETING BILLING/VERIFICATION (B/V) FORM

The form on the reverse side is the Mental Health Billing Verification (B/V) Form. It was designed for mental health providers to submit outpatient mental health counseling expenses to the State Board of Control (Board), which administers the Victims of Crime Program (Program). Board staff uses information on the form to verify expenses for payment. The form MUST be fully completed for payment to be considered. Incomplete forms will be returned. Only the B/V Form may be used as a bill. Services billed on this form may be reimbursed when:

- The claim has been found eligible by the Board;
- Services are provided by therapists who are licensed or otherwise authorized to receive reimbursements from the Program; and
- The percentage of treatment necessary to address the effects of the qualifying crime has been verified by Board staff.

Blank copies of this form may be copied. If the form is copied, we will accept only original signatures or initials. When completing this form, please remember:

- The submission of this form does not guarantee payment by the Board.
- The adult patient or legal guardian of a minor patient is ultimately responsible for any expenses incurred.
- All available sources of reimbursement must be billed first (in some cases, Medi-Cal can be the exception to this policy). Please be sure to check the “yes” or “no” box regarding Federal VOCA grants or matching funds.
- A separate B/V Form must be submitted for each qualifying direct or derivative victim receiving individual counseling. Family sessions involving the direct victim should be included on billing statements for the direct victim.

**WHO COMPLETES THE B/V FORM –** The provider is responsible for completing Section I and signing the form under the “Provider Declaration” statement. The B/V Form should not be submitted more than once a month, unless treatment has terminated.

**WHERE TO SUBMIT THE B/V FORM –** Submit the form to the Board at: P.O. Box 230, Sacramento, CA 94812. If the claim is being processed by a local Victim Witness Assistance Center, submit the form directly to the Center’s verification unit. If you are unsure who is processing the claim, you may call the Board’s toll-free number below or ask the patient.

**WHERE CAN MORE B/V FORMS BE OBTAINED AND WHERE TO CALL WITH QUESTIONS: –** If original copies are needed, or for specific questions on completing the form on existing claims, providers may call the Board toll-free at 1-800-777-9229.

**TREATING THERAPIST INFORMATION** – The name of the actual treating therapist, whether a licensed therapist or a registered intern, must be listed in the “Name of Treating Therapist” section. Information on the therapist supervising an intern who provides treatment must be listed in the “Supervising Therapist” section. If the treating therapist is not licensed, list the address and tax identification number of the treating therapist’s supervisor or the organization or facility’s name, whichever is to be designated as the payee.

**TOTAL CHARGES** – DO NOT include balance forward information.

**PATIENT DECLARATION** – The patient, or the parent or guardian of minor patients, must sign in Section II to confirm the relevance and receipt of the services for which payment is claimed.